



File# \_\_\_\_\_



Malinoski & Associates, D.D.S., P.C.

717 Health Parkway  
Three Rivers, MI 49093  
(269) 279-7876

Date: \_\_\_\_\_

### Confidential Patient Registration

In order to help us render the proper dental services to you, please answer the following questions. Please note the space for remarks for any question that requires clarification or any other information you think we should know. Thank you for your cooperation.

NAME: \_\_\_\_\_ SS NO: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ OTHER PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ SEX: M F

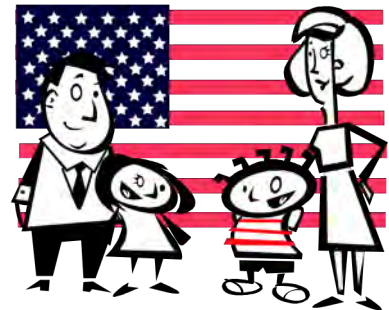
MARITAL STATUS: \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed

SPOUSE

NAME: \_\_\_\_\_

BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS NO: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

In case of emergency:  
NOTIFY: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PHONE: ( ) \_\_\_\_\_ - \_\_\_\_\_  
RELATIONSHIP: \_\_\_\_\_



How did you hear of our office? \_\_\_\_\_

**DENTAL INSURANCE: I am insured by the following plans:**

	1	2	3
Subscriber			
Birthdate			
SS#			
Insurance Co.			
Group #			
Employer			
Relationship			

**\*\*\*ALL MINORS MUST HAVE A PARENT PRESENT WITH THEM AT EACH VISIT\*\*\***

**17 OR YOUNGER OR GUARDIANSHIP**

**SUPPORT INFORMATION:**

If patient is 17 years or younger or under guardianship, fill in the following.

**PARENT / GUARDIAN:**

NAME: \_\_\_\_\_

BIRTHDAY: \_\_\_\_/\_\_\_\_/\_\_\_\_

SS# \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (        ) \_\_\_\_\_ - \_\_\_\_\_

Does the patient live with you? \_\_\_\_\_ YES      \_\_\_\_\_ NO

If not, what is your:

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

I understand that responsibility for payment for Dental Services provided for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. In the event of default I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. Malinoski and Associates complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Patient, Parent or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_